Expenses on Books or Federal Tax Return Not on Cost Report - Lines 234 & 235 - Itemize each expense reflected in the books or federal tax return and not included in the cost report. These expenses should be recorded in the appropriate column under books and/or federal tax return as an offset to the total expense in that column. Use an additional schedule if necessary to list expenses.

Expenses on Cost Report Not on Books or Federal Tax Return - Lines 237 & 238 - Itemize the expense reflected in the cost report but not in the total from the books or tax return. These items should be offset to the total expense in Column 3 - Cost Report. Use an additional schedule if necessary.

Totals - Line 240 - The differences between the totals per lines 231 (books), 232 (federal tax return) and 233 (cost report) less the negative adjustments in lines 234 - 238 in each of the three columns shall be entered on line 240. The adjusted totals per the books, federal tax return and cost report shall agree after the applicable offsets to the total expenses reported.

Nursing Facilities Attached to Hospitals: A nursing facility that is attached or associated with a hospital and shares expenditures shall submit the cost report (MS-2004), census sheets (AU-3902), and the following Medicare schedules: W/S A, A-6, A-8, B Part I and B-1. Also include the working trial balance that includes both the hospital and the long-term unit.

A "step-down process" will be run using the statistical information from W/S B-1 and the net expenses for cost allocation from Column 0 on W/S B Part 1. This will provide the indirect long-term care unit costs. Based on the long term care cost to net expense ratio, each department cost will be allocated to the appropriate line of the cost report. The total cost reported on the cost report should equal the long-term care total, Column 25, on W/S B Part 1.

Working Trial Balance: The working trial balance should reflect how the costs on the books are reported on the Nursing Facility Financial and Statistical Report. This detailed reconciliation also applies to providers who use a different fiscal year end for IRS but are reporting on the required calendar year end, beginning in 1991, for Medicaid rate setting purposes.

SCHEDULE C - STATEMENT OF OWNERS AND RELATED PARTIES

General: List all owners of the provider entity with 5% or more ownership interest and all related parties (KAR 30-10-24). Fill out Schedule C completely and accurately. Attach an additional schedule if more explanation or space is needed. Providers shall base all allocations on reasonable factual information and make the information available on request. Such information shall include details of dates, hours worked, nature of work performed, how it relates to resident care and the prevailing wage rates for such activities.

ENTER - Name, Social Security Number and Address

Column (1) - % of ownership (if applicable) or state the relationship to owner

Column (2) - % of time devoted to this facility per customary workweek

Column (3) - Total salaries, drawings, consulting fees, and other payments to owners and related parties as defined in KAR 30-10-1a and KAR 30-10-24.

Column (4) - List the titles, functions or descriptions of the jobs performed or transactions made with all owners and related parties. The job titles should correspond with those included in the Owner/Related Party Salary Chart prepared by SRS (please refer to KAR 30-10-24).

Column (5) - Enter the distribution by cost report line item of the total compensation incurred for all job functions. Owner/related party compensation shall be reported on the owner compensation expense line (107, 129, 143, 165, 172 and 202) in Schedule A.

Totals - The total compensation in Column 3 and Column 5 should agree. These two totals should also agree with the total of lines 107, 128, 143, 165, 172 and 202 Schedule A.

SCHEDULE D - STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE

Note: Please submit copies of loan agreements and amortization schedules with this cost report for all loans of $5,000 or more. Failure to document interest expense is cause for disallowance. (KAR 30-10-15b). Schedules need to be submitted for related party loans showing the interest paid, check numbers and dates.

Column (1) - Enter the original date and duration of the loan in months.

Column (2) - Enter the interest rate. If it is a variable rate, provide the range of the interest rates for the cost report period.

Column (3) - Enter the amount of the loan.

Column (4) - Enter the unpaid principal balance at the end of the cost report period. The total of Column 4, Line 311, must agree with the Balance Sheet, Schedule E.

Column (5) - Enter the total amount of interest and principal payments made during the cost report year.

Column (6) - Enter the total amount of interest incurred during the cost report year. The total of Column 6, Line 311 must agree with the total interest reported on Schedule A, Lines 115 and 191.

Lines 301 - 306 - Enter each lender's name, address and the items financed. Place a check in the appropriate box for interest expense reported on line 115 or line 191 of Schedule A. If interest expense on a loan is pro-rated to both lines, show the breakdown.

Line 311 - Enter the totals of Column 4 - Unpaid Balance and Column 6 - Interest Expense, for Lines 301-306 as reported on lines 115 and 191 in Schedule A.

SCHEDULE E - BALANCE SHEET

General: The balance sheet should be prepared from the books of the specific facility for which the cost report is filed. In other words, chain units should report only those balance sheet accounts that relate to the particular facility for which the cost report applies. Subject to the above, the balance sheet must be prepared in conformity with Generally Accepted Accounting Principles. Report all ownership claims that are customarily used by your particular type of entity. A partial listing of these accounts by type of entity follows:

Individual Proprietor ..... Owner's Capital
Partnership ..... Partner's Capital Accounts
Not-For-Profit Entities ..... Fund Balance
Corporation ..... Common Stock, Additional Paid In Capital, Retained Earnings
Chain Unit – All Chain Units ..... Central or Home Office Account
(regardless of type of ownership)

NOTE: Beginning of period account balances shall be reported for providers allowed to submit projected cost reports.

Lines 355, 356, 357, & 373 - If the amount reported exceeds $10,000, attach a schedule showing the details.

SCHEDULE F - RECONCILIATION OF BEGINNING AND ENDING RESIDUAL BALANCES

General: This schedule explains the change in owner's equity or the fund balance from the beginning to the end of the cost reporting period.

Beginning Balance

Line 401 - Enter the beginning owner's equity or fund balance. This is the total of Column 2 lines 377-379 in the Balance Sheet, Schedule E.

Increase to Owner's Equity or Fund Balance

Line 402 - Enter total revenue from Schedule G, Column 1, Line 449.

Line 403 - Enter the total of cash or other assets transferred or contributed by the owners.

Line 404 - Enter the total of cash or other assets transferred or contributed by the central office.

Line 405 - Enter the proceeds from the sale of common stock.

Line 406 & 407 - Enter and specify all other transactions which increase the residual owner equity or fund balance accounts.

Line 408 - Enter the total of Lines 402-407.

Decreases to Owner's Equity or Fund Balance

Line 411 - Enter the total expenses per Schedule A, Column 2, Line 215.

Line 412 - Enter total of cash or other assets withdrawn by the owners but not reported in the Expense Statement, Schedule A.

Line 413 - Enter total cash or other assets withdrawn by the central office.

Line 414 - Enter the total of duly declared dividends paid to stockholders.

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Line 415 - Enter the depreciation expense in excess of the straight line method unless reflected as a negative adjustment in Schedule A, Line 194, Column 3.

Line 416 & 417 - Enter and specify all other transactions which decrease the residual owner equity or fund balance accounts.

Line 418 - Enter the totals of Lines 411-417.

Ending Balance

Line 419 - Enter the net of adding lines 401 and 408 and subtracting line 418. The balance at the end of the period (line 419) should equal the total of Column 4, lines 377-379 in the Balance Sheet, Schedule E.

SCHEDULE G - REVENUE STATEMENT

Column 1 - Enter the revenues from the general ledger accounts on the appropriate lines. Revenues from services not designated on this schedule must be identified and reported on lines 447 and 448. The amount of the total revenue entered on line 449, Column 1 must also be entered on line 402, Beginning and Ending Residual Balances Reconciliation, Schedule F.

Column 2 - Enter the amount of the offset to the appropriate expense accounts. **Note the Following:** The amount of the offset should be the cost of reimbursable expenses. Non-reimbursable items (i.e., Beauty & Barber, Vending) are offset at cost.

Column 3 - Enter the line number of the expense reported on the Expense Statement, Schedule A, against which the offset has been made. The amount of the offset must be entered in Column 3, Provider Adjustments, on the Expense Statement, Schedule A.

Line 437 - Routine Nursing supplies sold to private pay residents.

(1) There is no offset required for routine items covered under KAR 30-10-15a that are sold to private pay residents; and

(2) None of the items covered under KAR 30-10-15a can be sold to Medicaid residents.

Line 440 - Resident Purchases/Non Routine Items Sold - Enter the total of all reimbursements for personal purchases not designated as routine items in KAR 30-10-15a.

Line 446 - Day Care/Treatment Income - Enter total revenue from all sources for day care, day treatment and respite care programs.

SCHEDULE H - STATEMENT OF RELATED ADULT CARE HOME INFORMATION

General: All Kansas facilities operated by common ownership or related parties shall be listed. Common ownership and related parties are defined in KAR 30-10-1a. Additional schedules shall be attached as necessary.

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SCHEDULE I - FIXED ASSETS, DEPRECIATION AND AMORTIZATION QUESTIONNAIRE

General: Each question shall be answered completely and accurately.

Lines 482-489 - Complex Capital Structures:

Attach a complete explanation of the ownership/management structure of the nursing facility including owners with 5% or more interest in the property and/or business, related parties as defined in KAR 30-10-1a, and all relevant contracts, leases, and assignments. This information must be accurate and comprehensive enough to present a true and clear account of the ownership and control of the adult care home.

Line 491 - If the facility is leased, a copy of the original lease agreement and subsequent amendments and/or agreements shall be submitted and on file with the agency. A provider making payments under Industrial Revenue Bonds with a nominal purchase upon maturity shall report the cost of ownership versus lease expense.

Line 494 - A new provider which purchases a facility shall submit a copy of the loan agreement(s), and any other pertinent information concerning the transaction.

Line 495 - Submit a copy of the detailed depreciation schedule with the cost report. Each asset shall be listed with the cost, date of purchase, life, salvage value, accumulated depreciation expense and current depreciation expense. Depreciation must be computed using the STRAIGHT LINE method. If the provider has filed a detailed depreciation schedule with the agency, an annual submission of addition and deletion schedules and a summary of depreciation expense is permissible.

SCHEDULE J - EMPLOYEE TURN OVER REPORT

Column 2 - Show the total number of employees at the beginning of the cost report period for each classification.

Column 3 - Show the total number of employees hired during the cost report period for each classification.

Column 4 - Show the total number of employees who ended employment during the cost report period for each classification.

Column 5 - Show the total number of employees at the end of the cost report period for each salary classification.

Column 6 - From the total number of employees listed in column 5, show how many are full-time and how many are part-time.

The number of employees listed in column 2, plus the number of employees listed in Column 3, less the number of employees reflected in Column 4, should equal Column 5. Please explain any discrepancy. The W-2's are an excellent source of information for the calendar year end cost report.

ATTENTION

Please make sure that all required documents are submitted with the cost reports. Review the list of questions following Schedule J in the Cost Report.

DECLARATION STATEMENT

Declaration by Owner; Partner; or Officer of the Corporation, City or County which is the Provider: The cost report is not considered complete unless signed by an owner or authorized agent of the facility and/or business and the preparer. If the facility/business owner and the preparer are the same individual, please sign both spaces. Print the names of the owner/authorized agent and preparer in the space provided. PLEASE READ DECLARATION STATEMENT.

State of Kansas
Department of Social and Rehabilitation Services
Medical Services

MS-2004
REV. 12/93

NURSING FACILITY FINANCIAL AND STATISTICAL REPORT

SEND TO:

KANSAS DEPT OF SOCIAL & REHABILITATION SERVICES
NURSING FACILITY REIMBURSEMENT
INCOME SUPPORT/MEDICAL SERVICES COMMISSION, 6TH FLOOR
DOCKING STATE OFFICE BUILDING
915 S.W. HARRISON
TOPEKA, KANSAS 66612-1570

AGENCY USE ONLY		
(1,2)		
(3,4)		
(5,6)		

INSTRUCTIONS AND REGULATIONS ARE AN INTEGRAL PART OF THIS REPORT. YOU MUST READ THEM BEFORE COMPLETING.

PROVIDER ID NUMBER: 4 | | | | | |

11. EMPLOYER'S FEDERAL ID NUMBER

12. PROVIDER NAME (THE PERSON OR BUSINESS ORGANIZATION RESPONSIBLE FOR MEETING REQUIREMENTS, PROVIDING SERVICES AND RECEIVING PAYMENTS.)

13. FACILITY NAME

14. & 15. FACILITY ADDRESS (STREET, CITY, STATE, ZIP)

16. ADMINISTRATOR'S NAME	17. PHONE NUMBER	18. REPORT PERIOD	19. FISCAL YEAR END
	( )	/ / TO / /	/ /

CHECK ONLY ONE

21. ____ EXISTING FACILITY (HISTORICAL)
22. ____ NEW PROVIDER (PROJECTED)
23. ____ NEW FACILITY (PROJECTED)
24. ____ HISTORICAL F/Y SAME AS PROJECTED PERIOD
25. ____ HISTORICAL F/Y OVERLAPS PROJECTION PERIOD

CHECK ONLY ONE

26. ____ SOLE PROPRIETORSHIP
27. ____ PARTNERSHIP
28. ____ CORPORATION-PROFIT
29. ____ CORPORATION-NON PROFIT
30. ____ CITY OWNED
31. ____ COUNTY OWNED
32. ____ OTHER (SPECIFY)

FACILITY BEDS	(1) BEG OF PERIOD	(2) INCREASE (DECR)	(3) DATE OF CHANGE	(4) END OF PERIOD
41. NURSING FACILITY (NF)				
42. NF-MENTAL HEALTH				
44. OTHER				
45. TOTAL LICENSED BEDS				

46. TOTAL BED DAYS		
48. TOTAL RESIDENT DAYS (ALL RESIDENTS FROM AU-3902)	(4)	
48a. TOTAL MEDICAID DAYS	(5)	
48b. TOTAL MEDICARE DAYS		

51. IF PROVIDER IS A CORPORATION, IS IT A PUBLICLY HELD CORPORATION? ☐ YES ☐ NO
IF YES, ATTACH A COPY OF THE ANNUAL REPORT TO STOCKHOLDERS AND A FORM 10-K.

52. DOES THE FACILITY HAVE MEDICARE CERTIFIED BEDS? ☐ YES ☐ NO

53. IS THIS FACILITY (please check one): ☐ HOSPITAL BASED LTC ☐ FREE-STANDING NF

This form Supersedes Form 2004, Rev. 12/92. Page 1 of 16

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE

PROVIDER NUMBER

EDULE A — EXPENSE STATEMENT

ADMINISTRATION COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
SALARY - ADMINISTRATOR	101						
SALARY - CO ADMINISTRATOR	102						
OTHER ADMINISTRATIVE SALARIES	103						
EMPLOYEE BENEFITS	104						
OFFICE SUPPLIES & PRINTING	105						
MANAGEMENT CONSULTANT FEES	106						
OWNER/RELATED PARTY COMPENSATION – SCHEDULE C	107						
A ATION OF CENTRAL OFFICE COSTS (SEE INSTRUCTIONS)	108						
PHONE & OTHER COMMUNICATION	109						
TRAVEL	110						
ADVERTISING	111						
LICENSES & DUES	112						
LEGAL, ACCOUNTING, & DP	113						
INSURANCE (EXCEPT LIFE)	114						
INTEREST (EXCEPT RE LOANS)	115						
OTHER (PLEASE SPECIFY)	117						
OTHER (PLEASE SPECIFY)	118						
TOTAL ADMINISTRATION COST CENTER	120						

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER

SCHEDULE A — EXPENSE STATEMENT

PLANT OPERATING COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
REAL & PERSONAL PROPERTY TAX	121						
SALARIES	126						
EMPLOYEE BENEFITS	127						
OWNER/RELEATED PARTY COMPENSATION SCHEDULE C	128						
UTILITIES (EXCEPT PHONE)	129						
MAINTENANCE & REPAIRS	130						
SUPPLIES	131						
SMALL EQUIPMENT (SEE INSTRUCTIONS)	137						
OTHER (PLEASE SPECIFY)	138						
TOTAL PLANT OPERATING COST CENTER	139						

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DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE

PROVIDER NUMBER

EDULE A — EXPENSE STATEMENT

ROOM & BOARD COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
EMPLOYEE BENEFITS	141						
DIETARY:							
SALARIES	142						
OWNER/RELATED PARTY COMPENSATION– SCHEDULE C	143						
DIETARY CONSULTANT	144						
FOOD	145						
SUPPLIES	146						
OTHER (PLEASE SPECIFY)	148						
LNDRY & LINEN:							
SALARIES	149						
LINEN & BEDDING MATERIAL	150						
SUPPLIES	151						
OTHER (PLEASE SPECIFY)	153						
HOUSEKEEPING:							
SALARIES	154						
SUPPLIES	155						
OTHER (PLEASE SPECIFY)	158						
TOTAL ROOM & BOARD COST CENTER	159						

MS-20C4

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER

SCHEDULE A — EXPENSE STATEMENT

HEALTH CARE COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
NURSING:							
REGISTERED NURSE (RN)	161						
LICENSED PRACTICAL NURSE	162a						
LICENSED MENTAL HEALTH TECH	162b						
NURSE AIDES	163a						
MEDICATION AIDES	163b						
RESTORATIVE/REHAB AIDES	163c						
EMPLOYEE BENEFITS	164						
OWNER/RELATED PARTY COMP-SCHEDULE C	165						
NURSING CONSULTANTS	166						
PURCHASED SERVICES	167						
NURSING SUPPLIES	168						
OTHER (PLEASE SPECIFY)	170						
OTHER PATIENT SERV:							
PHY. THERAPIST SALARY	171a						
OCC. THERAPIST SALARY	171b						
SPEECH THERAPIST SALARY	171c						
RESPIRATORY THRP SALARY	171d						
PSYCH. THERAPIST SALARY	171e						
REC. THERAPIST SALARY	171f						
OWNER/RELATED PARTY COMP-SCHEDULE C	172						
RESIDENT ACTIVITIES SALARY	173a						
SOCIAL WORKER SALARY	173b						
MEDICAL RECORDS SALARIES	173c						
OTHER HC SALARIES (SPECIFY)	173d						
RES ACT SUPPLIES	174						

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER

EDULE A — EXPENSE STATEMENT

HEALTH CARE COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
OTHER PATIENT SERV:(CONT)							
OCCU. THERAPY - CONSULT	175						
MEDICAL RECORDS-CONSULT	176						
PHARMACIST - CONSULTANT	177						
SPEECH THERAPY-CONSULT	178						
PHYSICAL THER- CONSULT	179						
CONSULTANT	180						
NURSE AIDE TRAINING	181a						
OTHER HEALTH CARE TRAIN.	181b						
RESIDENT TRANSPORT	182						
OTHER (PLEASE SPECIFY)	183						
OTHER (PLEASE SPECIFY)	188						
TOTAL- HEALTHCARE COST CENTER	189						
TOTAL- RATE FORMULA COSTS	190						

OWNERSHIP COST CENTER							
INTEREST - REAL ESTATE	191						
RENT/LEASE EXPENSE	192						
AMORTIZED LEASEHOLD IMPROVEMENT	193						
DEPRECIATION EXPENSE	194						
TOTAL OWNERSHIP COST CENTER	195						

MS-20C4

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER

SCHEDULE A — EXPENSE STATEMENT

NON-REIMBURSABLE & NON-RESIDENT RELATED EXPENSE ITEMS	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
BAD DEBTS	200				0		
PROVISION FOR INCOME TAXES	201				0		
NON WORKING OWNERS/OFFICERS-SCH C	202				0		
DONATIONS	203				0		
FUND RAISING/PROMO & NON REIMB. ADVERTISING	204				0		
LIFE INSURANCE – OWNERS/OFFICERS	205				0		
OXYGEN PURCHASES & SUPPLIES	206				0		
DRUGS - PHARMACEUTICALS	207				0		
VENDING MACHINES	208				0		
BOARD OF DIRECTORS EXP	209				0		
RESIDENT PURCHASES	210				0		
BARBER/BEAUTY SHOP	211				0		
OTHER (PLEASE SPECIFY)	212				0		
OTHER (PLEASE SPECIFY)	213				0		
TOTAL NON-REIMBURSABLE	214				0		
TOTAL	215						

ATTACH A DETAILED DEPRECIATION SCHEDULE AND THE DETAILED WORKING TRIAL BALANCE USED TO PREPARE THIS COST REPORT

PROVIDER NUMBER

SCHEDULE B EXPENSE RECONCILIATION

	LN#	(1) BOOKS	(2) FED TAX RETURN	(3) COST REPORT
TOTAL EXPENSES PER BOOKS	231			
TOTAL EXPENSES PER FEDERAL TAX RETURN	232			
TOTAL EXPENSES PER COST REPORT (LINE 215, COLUMN 2)	233			
EXPENSES ON BOOKS OR FEDERAL TAX RET NOT ON COST REPORT				
SPECIFY	234			
SPECIFY	235			
EXPENSES ON COST REPORT NOT ON BOOKS OR FEDERAL TAX RETURN				
SPECIFY	237			
SPECIFY	238			
TOTAL (SHOULD BE EQUAL)	240			

SCHEDULE C STATEMENT OF OWNERS AND RELATED PARTIES

LIST ALL OWNERS OF PROVIDERS WITH 5% OWNERSHIP INTEREST & ALL RELATED PARTIES. IF ANY OWNERS ARE OTHER THAN INDIVIDUAL, READ AND FOLLOW INSTRUCTIONS CAREFULLY CONCERNING REQUIREMENTS FOR COMPLEX CAPITAL STRUCTURES. ALSO SUMMARIZE THE AMOUNT AND NATURE OF TRANSACTIONS WITH ALL OWNERS & RELATED PARTIES. FOR DEFINITIONS SEE KAR 30-10-1a AND 30-10-24.

NAME, SSN, ADDRESS (CITY & STATE)	(1) % OWNERSHIP	(2) % TIME DEVOTED	(3) TOTAL AMT INCURRED	(4) TITLE, FUNCTION OR DESCRIPTION - TRANSACTION	(5) DISTRIBUTION	
					AMOUNT	LINE #
TOTALS (SHOULD BE EQUAL)						

CALCULATIONS MUST EQUAL THE OWNER/RELATED PARTY LINES OF 107, 128, 143, 165, 172, & 202.

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30-10-17 (32) MS-2004

STATEMENT RELATED TC INTEREST

PROVIDER NUMBER

SCHEDULE D ON ALL BONDS, LOANS, NOTES AND MORTGAGES PAYABLE

LN#						
301	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 191 ☐
	(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	(6) INTEREST EXPENSE
302	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 191 ☐
	(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	(6) INTEREST EXPENSE
303	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 191 ☐
	(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	(6) INTEREST EXPENSE
304	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 191 ☐
	(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	(6) INTEREST EXPENSE
305	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 191 ☐
	(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	(6) INTEREST EXPENSE
306	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 191 ☐
	(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	(6) INTEREST EXPENSE
311	TOTALS: Line 115					
	Line 191					

TOTAL OF COLUMN 6 MUST AGREE WITH THE SUM OF LINES 115 & 191. ENTRIES IN COLUMN 4 MUST AGREE WITH THE BALANCE SHEET. ATTACH A COPY OF LOAN AGREEMENTS AND AMORTIZATION SCHEDULES FOR ALL LOANS OF $5,000 OR MORE IF NOT ALREADY SUBMITTED.

PROVIDER NUMBER

SCHEDULE E — BALANCE SHEET

BALANCE SHEET SHALL REFLECT THE ASSET, LIABILITY AND RESIDUAL ACCOUNTS OF THIS FACILITY ONLY

		BEGINNING OF PERIOD		END OF PERIOD	
ASSETS	LN#	(1)	(2)	(3)	(4)
CASH	351				
ACCOUNTS RECEIVABLE	352				
LESS: ALLOWANCE FOR DOUBTFUL ACCT	353	( )		( )	
INVENTORIES & SUPPLIES	354				
*ALL LOANS TO OFFICERS, OWNERS, AND RELATED PARTIES	355				
*ALL ASSETS NOT REL-PATIENT CARE	356				
*ASSETS HELD FOR INVESTMENT	357				
NURSING HOME PLANT & EQUIPMENT:					
BUILDING	358				
LESS: ACCUMULATED DEPRECIATION	359	( )		( )	
EQUIPMENT	360				
LESS: ACCUMULATED DEPRECIATION	361	( )		( )	
LEASEHOLD IMPROVEMENTS	362				
LESS: ACCUMULATED DEPRECIATION	363	( )		( )	
LAND	364				
OTHER	365				
OTHER	366				
TOTAL ASSETS	369				
LIABILITIES & OWNER'S EQUITY					
ACCOUNTS PAYABLE	371				
OTHER CURRENT LIABILITIES	372				
*ALL LOANS FROM OFFICERS, OWNERS AND RELATED PARTIES	373				
MORTGAGE PAYABLE	374				
OTHER LONG TERM LIABILITIES	375				
OWNER'S EQUITY OR FUND BALANCE (LIST APPROPRIATE ACCOUNTS & AMOUNTS – SEE INSTRUCTIONS)					
	377				
	378				
	379				
TOTAL LIAB & OWNER'S EQUITY	380				

*IF AMOUNTS EXCEED $10,000 ATTACH SCHEDULE SHOWING DETAILS

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SCHEDULE F	BEGINNING & ENDING RESIDUAL BALANCES RECONCILIATION		
BALANCE AT BEGINNING OF PERIOD-LINE 377, 378 & 379, COLUMN 2	401		
INCREASES:			
REVENUE PER LINE 449, COLUMN 1	402		
INVESTMENT BY OWNER	403		
TRANSFERS FROM CENTRAL OFFICE	404		
COMMON STOCK SOLD	405		
OTHER (SPECIFY)	406		
OTHER (SPECIFY)	407		
TOTAL INCREASES	408		
DECREASES:			
EXPENSES PER SCHEDULE A, LINE 215, COLUMN 2	411		
WITHDRAWAL BY OWNERS NOT IN SCHEDULE A	412		
TRANSFERS TO CENTRAL OFFICE	413		
DIVIDENDS PAID TO STOCKHOLDERS	414		
DEPRECIATION EXPENSE IN EXCESS OF STRAIGHT LINE	415		
OTHER (SPECIFY)	416		
OTHER (SPECIFY)	417		
TOTAL DECREASES	418		( )
BALANCE AT END OF PERIOD-LINE 377, 378 & 379, COLUMN 4	419		

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SCHEDULE G — REVENUE STATEMENT

	LN#	(1) REV PER BOOKS OR FED TAX RETURN	(2) ADJUSTMENT TO EXPENSE ACCOUNTS	(3) LINE NUMBER OF RELATED EXPENSE
ROUTINE DAILY SERVICE:				
PRIVATE PAY RESIDENTS	431			
MEDICAID RESIDENTS & PATIENT LIABILITY	432			
MEDICARE RESIDENTS	433			
VETERAN ADMINISTRATION RESIDENTS	434			
OTHER RESIDENTS (SPECIFY)	435			
PHARMACY - DRUGS & MEDICATIONS	436			
ROUTINE NURSING SUPPLIES SOLD TO PRIVATE PAY RESIDENTS	437			
REVENUE FROM MEALS SOLD TO GUESTS & EMPLOYEES	438			
BEAUTY/BARBER SHOP	439			
[illegible]ENT PURCHASES/NON ROUTINE ITEMS SOLD	440			
PURCHASE DISCOUNTS, RETURNS & ALLOWANCES	441			
OTHER SUPPLIES SOLD	442			
PROGRAM REIMBURSEMENTS & TAX CREDITS	443			
INVESTMENT/INTEREST INCOME	444			
VENDING MACHINE REVENUE	445			
DAY CARE/TREATMENT INCOME	446			
OTHER (SPECIFY)	447			
OTHER (SPECIFY)	448			
TOTALS	449			

PROVIDER NUMBER

SCHEDULE H STATEMENT OF RELATED ADULT CARE HOME INFORMATION

461 DO ANY OF THE OWNERS, RELATED PARTIES OR EMPLOYEES HAVE INTEREST, DIRECTLY OR INDIRECTLY, IN ANY OTHER ADULT CARE HOME FACILITY LOCATED IN KANSAS (EXCEPT MINOR STOCK OWNERSHIP AS A PASSIVE INVESTMENT IN UNRELATED PUBLICLY HELD CORPORATIONS? ☐ YES ☐ NO

IF YOUR ANSWER IS NO, DO NOT COMPLETE THE REST OF THIS SCHEDULE, BUT GO TO SCHEDULE I.
IF YOUR ANSWER IS YES, LIST BELOW ALL ADULT CARE HOME FACILITIES LOCATED IN KANSAS IN WHICH AN INTEREST EXISTS OR THAT ARE UNDER COMMON CONTROL OR OWNERSHIP. ATTACH SCHEDULE IF NECESSARY.

	(1) RELATED PROVIDER'S NAME	(2) MEDICAID PROVIDER #	(3) DESCRIBE RELATIONSHIP: OWNERSHIP/MANAGEMENT/DIRECTORS
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PROVIDER NUMBER

SCHEDULE I FIXED ASSET, DEPRECIATION & AMORTIZATION QUESTIONNAIRE

481	DOES THE PROVIDER LEASE OR RENT ANY PART OF THE PHYSICAL FACILITY FROM ANY OTHER ENTITY?	☐ YES	☐ NO
482	IF YES, DO ANY OWNERS OF THE PHYSICAL FACILITY HAVE AN INTEREST, DIRECTLY OR INDIRECTLY, IN THE PROVIDER?	☐ YES	☐ NO

IF YES, PROVIDE THE OWNERSHIP INFORMATION REQUESTED BELOW. IF NO, GO TO QUESTION 493.

	NAME OF OWNERS OF PHYSICAL FACILITY	% OF OWNERSHIP	DESCRIBE NATURE OF RELATIONSHIP WITH PROVIDER. IF NONE, WRITE "NONE"
485			
486			
487			
488			
489			

IF THE OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW THE INSTRUCTIONS CAREFULLY CONCERNING REQUIREMENTS FOR COMPLEX CAPITAL STRUCTURES.

491	HAVE COPIES OF ALL LEASE AGREEMENTS (INCLUDING AMENDMENTS) BEEN SUBMITTED WITH A PREVIOUS COST REPORT? IF NO, SUBMIT COPIES OF DOCUMENTS NOT PREVIOUSLY SUBMITTED	☐ YES	☐ NO
492	DOES THE LEASE CONTAIN AN OPTION TO PURCHASE THE LEASED PROPERTY?	☐ YES	☐ NO
493	IS THE PHYSICAL FACILITY OWNED BY THE PROVIDER?	☐ YES	☐ NO
494	IF OWNED, WAS THE PURCHASE AN ARMS LENGTH TRANSACTION? (ATTACH A STATEMENT OUTLINING DETAILS OF THE PURCHASE)	☐ YES	☐ NO
495	WAS THE STRAIGHT LINE DEPRECIATION METHOD USED?	☐ YES	☐ NO
	IF NO, HAVE YOU RECALCULATED THE DEPRECIATION USING THE STRAIGHT LINE METHOD AND MADE THE APPROPRIATE ADJUSTMENTS TO THE DEPRECIATION EXPENSE REPORTED ON THE EXPENSE STATEMENT?	☐ YES	☐ NO
496	DID YOU ATTACH A DETAILED DEPRECIATION SCHEDULE & WORKING TRIAL BALANCE TO THIS COST REPORT? IF NO, SUMBIT COPIES OF DOCUMENT NOW	☐ YES	☐ NO

TN#MS-94-02 Approval Date JUN 06 2001 Effective Date 11/94 Supersedes TN#MS-92-32

30-10-17 (38) MS-2004

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SCHEDULE J EMPLOYEE TURNOVER REPORT

LN#	SALARY CLASSIFICATION	(2) BEGINNING # OF EMPLOYEES	(3) EMPLOYEES HIRED	(4) EMPLOYEES TERMINATED	(5) ENDING # OF EMPLOYEES	(6) HOW MANY FROM (5) ARE: FULL-TIME	PART-TIME
497	ADMINISTRATOR						
498	CO-ADMINISTRATOR						
499	OTHER ADMINISTRATIVE						
500	PLANT OPERATING						
501	DIETARY						
502	LAUNDRY						
503	HOUSEKEEPING						
504	REGISTERED NURSES						
505	LPN						
506	LICENSED M/H TECH						
507	AIDES						
508	PHYSICAL THERAPIST						
509	SPEECH THERAPIST						
510	OCCUPATIONAL THERAPIST						
511	RESPIRATORY THERAPIST						
512	PSYCH THERAPIST						
513	RECREATION THERAPIST						
514	RESIDENT ACTIVITY						
515	SOCIAL WORKER						
516	MEDICAL RECORDS						
517	OTHER HEALTH CARE						
518	TOTAL ALL CLASSIFICATION						

ATTENTION

COMPLETE THE COST REPORT ACCORDING TO THE INSTRUCTIONS AND ATTACH REQUIRED DOCUMENTS.

1. HAS THE REPORT BEEN SIGNED BY THE OWNER/AUTHORIZED AGENT AND THE PREPARER?
2. ARE ALL COST REPORTS SCHEDULES COMPLETE?.
3. ARE TWO (2) COPIES OF THE COMPLETED COST REPORT AND ONE COPY OF THE AU-3902 (CENSUS SHEET) BEING SUBMITTED?
4. ARE THE FOLLOWING DOCUMENTS ATTACHED TO THE COST REPORT, IF APPLICABLE?

(a) TRIAL BALANCE USED TO PREPARE THE COST REPORT ☐
(b) DEPRECIATION SCHEDULE ☐
(c) CENTRAL OFFICE COSTS AND ALLOCATION SCHEDULES ☐
(d) LOAN AGREEMENTS AND AMORTIZATION SCHEDULES (FOR LOANS OF $5,000 AND MORE) ☐
(e) CURRENT MANAGMENT CONSULTANT AGREEMENT ☐
(f) CENSUS SHEETS (AU-3902) ☐
(g) LEVEL OF CARE CHARGE SCHEDULES ☐
(h) SCHEDULE OF LOANS FROM OFFICERS, OWNERS AND RELATED PARTIES (FOR LOANS IN EXCESS OF $10,000) ☐